BREAST ASSESSMENT REQUEST FORM

St. Joseph's Health Care London **F: 519-646-6204** **DATE OF BOOKED EXAM:**_____

PATIENT INFORMATION:

Surname: _____ **First Name**: _____ **Middle Initial**:____

Gender: _____ **Date of Birth (YYYY-MM-DD):** _____

Street Address:_____**Apartment**:____**City**: _____ **Province**:____ **Postal Code**:_____

Health Card No.: _____ **Version Code**:_____ **MRN No.:** _____

Telephone (Day):_____ **(Evening)**: _____ **(Cell)**: _____

Mobility: ☐ **Ambulatory** ☐ **Wheelchair** ☐ **Stretcher** ☐ **Mechanical Lift** ☐ **Interpreter Required** _____(language)

****Patients that are 50 ≥ and <75 years with no implants and no previous breast cancer please refer to OBSP****

PREVIOUS IMAGING: ☐ **Y** ☐ **N** **WHERE/WHEN?**_____

***Please attach breast imaging reports NOT generated at St. Joseph's**

SCREENING: ☐ **Implants** ☐ **Y** ☐ **N**

DIAGNOSTIC: ☐ **NEW CLINICAL CONCERN:** ☐ **Y** ☐ **N**

HISTORY/CLINICAL FINDINGS: (required)**:**_____

PALPABLE LUMP: ☐ **RIGHT** ☐ **LEFT**

LUMP DETECTED BY: ☐ **PHYSICIAN** ☐ **PATIENT**

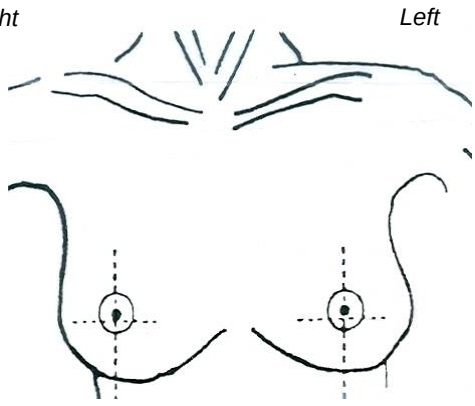
PAIN: ☐ **RIGHT** ☐ **LEFT**

☐ **FOCAL** ☐ **DIFFUSE** ☐ **INTERMITTENT**

NIPPLE DISCHARGE (only if spontaneous,non-milky): ☐ **RIGHT** ☐ **LEFT**

☐ **BLOODY** ☐ **OTHER**

Please Indicate ALL Clinical Concerns On Diagram



*****SCREENING BREAST ULTRASOUND IS NOT ROUTINELY PERFORMED AT ST. JOSEPHS HEALTH CARE LONDON*****

NOTE: By Signing this requisition, you are providing authorization to St. Joseph's for your patient to receive additional imaging and urgent surgical consultation, as required, to resolve this diagnostic request.

REFERRED BY (please print): _____ **PHYSICIAN SIGNATURE**: _____

Phone Number:_____ **Fax**: _____